FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040444

Facility Name: Sheridan Shores Care & Rehab Ctr

Address: 5838 North Sheridan Road (Number) Chicago (City) 60660 (Zip Code)

County: Cook

Telephone Number: (773) 769-2230 **Fax #** (773) 769-3579

HFS ID Number: 363873049001

Date of Initial License for Current Owners: 06/04/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Edward N. Slack, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	127	Skilled (SNF)	127	46,355	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	61	22,265	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	188	TOTALS	188	68,620	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,517	231	2,639	16,387	8
9	SNF/PED					9
10	ICF	47,850	538		48,388	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,367	769	2,639	64,775	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.40%

D. How many bed-hold days during this year were paid by the Department?
1,761 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 31 and days of care provided 2,523

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	232,128	34,726	11,318	278,172		278,172	1,068	279,240			1
2	Food Purchase		225,948		225,948	(25,806)	200,143	(26)	200,116			2
3	Housekeeping	154,660	32,635		187,295		187,295	(3,100)	184,195			3
4	Laundry	73,271	21,078		94,349		94,349		94,349			4
5	Heat and Other Utilities			196,308	196,308		196,308	2,561	198,869			5
6	Maintenance	176,487		110,038	286,525		286,525	(5,773)	280,752			6
7	Other (specify):*							1,478	1,478			7
8	**TOTAL General Services**	636,546	314,387	317,664	1,268,597	(25,806)	1,242,792	(3,793)	1,238,999			8
	B. Health Care and Programs											
9	Medical Director			4,100	4,100		4,100		4,100			9
10	Nursing and Medical Records	1,974,384	33,460	8,498	2,016,342		2,016,342	(2,178)	2,014,164			10
10a	Therapy	60,320			60,320		60,320	612	60,932			10a
11	Activities	80,540	15,403	196	96,139		96,139	(4)	96,135			11
12	Social Services	220,009	3,352	4,270	227,631		227,631		227,631			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							84	84			15
16	**TOTAL Health Care and Programs**	2,335,253	52,215	17,064	2,404,532		2,404,532	(1,485)	2,403,047			16
	C. General Administration											
17	Administrative	83,826		60,000	143,826		143,826	38,073	181,899			17
18	Directors Fees											18
19	Professional Services			132,199	132,199		132,199	(69,851)	62,348			19
20	Dues, Fees, Subscriptions & Promotions			48,466	48,466		48,466	(8,838)	39,628			20
21	Clerical & General Office Expenses	87,132	35,758	66,043	188,933		188,933	199,519	388,452			21
22	Employee Benefits & Payroll Taxes			511,146	511,146	25,806	536,952		536,952			22
23	Inservice Training & Education			1,029	1,029		1,029		1,029			23
24	Travel and Seminar			3,509	3,509		3,509	5,343	8,852			24
25	Other Admin. Staff Transportation			1,555	1,555		1,555		1,555			25
26	Insurance-Prop.Liab.Malpractice			174,401	174,401		174,401	1,909	176,310			26
27	Other (specify):*							31,437	31,437			27
28	**TOTAL General Administration**	170,958	35,758	998,348	1,205,064	25,806	1,230,870	197,592	1,428,461			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,142,757	402,360	1,333,076	4,878,193		4,878,193	192,313	5,070,506			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr #0040444 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			43,932	43,932		43,932	319,585	363,517			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,912	65,912		65,912	168,260	234,172			32
33	Real Estate Taxes			224,532	224,532		224,532	2,105	226,637			33
34	Rent-Facility & Grounds			1,109,920	1,109,920		1,109,920	(202,850)	907,070			34
35	Rent-Equipment & Vehicles			2,634	2,634		2,634	1,797	4,431			35
36	Other (specify):*			3,431	3,431		3,431	43,919	47,350			36
37	**TOTAL Ownership**			1,450,361	1,450,361		1,450,361	332,816	1,783,177			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,210	94,923	215,133		215,133	(8,441)	206,692			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,930	102,930		102,930		102,930			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		120,210	197,853	318,063		318,063	(8,441)	309,622			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,142,757	522,570	2,981,290	6,646,617		6,646,617	516,689	7,163,306			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	118,914	30		9
10	Interest and Other Investment Income	(1,726)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(26)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,554)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,736)	21		24
25	Fund Raising, Advertising and Promotional	(12,654)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(45,699)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 52,519		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	464,170		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 464,170		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 516,689		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Sheridan Shores Care & Rehab Ctr

ID# 0040444

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (338)	10	1
2	Rental Income	(6,432)	06	2
3	Prior Year Legal Fees	(2,333)	19	3
4	Jury Duty	(34)	10	4
5	Miscellaneous Income	(13,064)	21	5
6	COPE Dues	(604)	20	6
7	Capitalized R&M	(10,702)	06	7
8	Collection Expenses	(6,949)	21	8
9	Non Allowable Professional Fees	(5,163)	19	9
10				10
11				11
12				12
13				13
14				14
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96				96
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98				98
99				99
100				100
101	**Total**	(45,699)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				77	407	4,641	(4,057)					1,068	1
2	Food Purchase	(26)											(26)	2
3	Housekeeping				(3,100)								(3,100)	3
4	Laundry													4
5	Heat and Other Utilities					2,561							2,561	5
6	Maintenance	(17,134)			(542)	6,258	5,645						(5,773)	6
7	Other (specify):*						1,478						1,478	7
8	**TOTAL General Services**	(17,160)			(3,565)	9,226	11,764	(4,057)					(3,793)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(372)			(1,806)								(2,178)	10
10a	Therapy						612						612	10a
11	Activities				(4)								(4)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*						84						84	15
16	**TOTAL Health Care and Programs**	(372)			(1,809)		696						(1,485)	16
	C. General Administration													
17	Administrative					4,196	33,877						38,073	17
18	Directors Fees													18
19	Professional Services	(7,496)				(62,355)							(69,851)	19
20	Fees, Subscriptions & Promotions	(14,338)			(5)	5,504							(8,838)	20
21	Clerical & General Office Expenses	(25,303)	19,130			20,456	185,236						199,519	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar					5,343							5,343	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					1,909							1,909	26
27	Other (specify):*						31,437						31,437	27
28	**TOTAL General Administration**	(47,137)	19,130		(5)	(24,947)	250,550						197,592	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(64,669)	19,130		(5,379)	(15,721)	263,010	(4,057)					192,313	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Sheridan Shores Care & Rehab Ctr** **#** **0040444** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	118,914	173,997			26,674							319,585	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,726)	165,533			4,453							168,260	32
33	Real Estate Taxes					2,105							2,105	33
34	Rent-Facility & Grounds		(212,821)			9,971							(202,850)	34
35	Rent-Equipment & Vehicles					1,797							1,797	35
36	Other (specify):*		43,919										43,919	36
37	**TOTAL Ownership**	117,188	170,628			45,000							332,816	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(2,089)			(6,352)					(8,441)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**				(2,089)			(6,352)					(8,441)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	52,519	189,758		(7,468)	29,279	263,010	(10,409)					516,689	45

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 821,725	Edgewater Care & Rehab Center Building, LLC		$ 885,100	$ 63,375	1
2	V	32	Interest	14,038	Edgewater Care & Rehab Center Building, LLC			(14,038)	2
3	V	36	Amortization		Edgewater Care & Rehab Center Building, LLC		43,919	43,919	3
4	V	21	Bank Charges		Edgewater Care & Rehab Center Building, LLC		320	320	4
5	V	21	Other Income	451,200				(451,200)	5
6	V								6
7	V	34	Rent	276,196	Sheridan Shores Property			(276,196)	7
8	V	21	Administrative Expenses		Sheridan Shores Property		10	10	8
9	V	21	Non-Compete Fee		Sheridan Shores Property		470,000	470,000	9
10	V	32	Interest		Sheridan Shores Property		179,571	179,571	10
11	V	30	Depreciation		Sheridan Shores Property		173,997	173,997	11
12	V								12
13	V								13
14	Total			$ 1,563,159			$ 1,752,917	$ * 189,758	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 68,398	$ 68,398	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	68,398	CCS EMPLOYEE BENEFIT GROUP	100.00%		(68,398)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 68,398			$ 68,398	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ (773)	XCEL MEDICAL SUPPLY, LLC	100.00%	$ (696)	$ 77	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	31,270	XCEL MEDICAL SUPPLY, LLC	100.00%	28,170	(3,100)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE	5,465	XCEL MEDICAL SUPPLY, LLC	100.00%	4,923	(542)	19
20	V	10	NURSING	18,213	XCEL MEDICAL SUPPLY, LLC	100.00%	16,408	(1,806)	20
21	V	11	ACTIVITIES	38	XCEL MEDICAL SUPPLY, LLC	100.00%	34	(4)	21
22	V	20	DUES, FEES, SUBSCRIPTIONS & PROM	46	XCEL MEDICAL SUPPLY, LLC	100.00%	41	(5)	22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39	ANCILLARY	21,068	XCEL MEDICAL SUPPLY, LLC	100.00%	18,979	(2,089)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 75,328			$ 67,860	$ * (7,468)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 407	$ 407	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	2,561	2,561	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	6,258	6,258	17
18	V				Care Centers, Inc.	100.00%			18
19	V	17	Administration		Care Centers, Inc.	100.00%	4,196	4,196	19
20	V	19	Professional Fees	85,852	Care Centers, Inc.	100.00%	23,497	(62,355)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	5,504	5,504	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	20,456	20,456	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	5,343	5,343	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,909	1,909	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	26,674	26,674	25
26	V	32	Interest		Care Centers, Inc.	100.00%	4,453	4,453	26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,105	2,105	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	9,971	9,971	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,797	1,797	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 85,852			$ 115,131	$ * 29,279	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 4,641	$ 4,641	15
16	V								16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	5,645	5,645	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,478	1,478	18
19	V								19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%	612	612	20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	84	84	21
22	V								22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	33,877	33,877	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	185,236	185,236	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	31,437	31,437	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 263,010	$ * 263,010	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 4,057	Care Centers, Inc. - Health Systems Division	100.00%	$ 516	$ (4,057)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	2,134		16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	18		17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	132		18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	3		19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	4		20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	304		21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	105		22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	94		23
24	V	30	Depreciaton		Care Centers, Inc. - Health Systems Division	100.00%	50		24
25	V	32	Interest		Care Centers, Inc. - Health Systems Division	100.00%	169		25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	9		26
27	V	39	Ancillary Enteral Supplies	6,352	Care Centers, Inc. - Health Systems Division	100.00%	3,342	(6,352)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,800		28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	273		29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 10,409			$ 8,953	$ * (10,409)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	3.19%	See Attached	1.37	2.98%	Alloc Salary	$ 3,305	17-7	1
2	Gale Rothner	Owner	Administrative	15.96%	See Attached	1.51	4.32%	Alloc Salary	3,374	17-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	2.38	4.33%	Alloc Salary	3,183	17-7	3
4	Adam Vales	Relative	Clerical		See Attached	0.45	1.13%	Alloc Salary	558	22-7	4
5	Kim Rudolph	Relative	Clerical		See Attached	0.56	1.60%	Alloc Salary	1,004	22-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,424		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURAI	DIRECT ALLOCATION			$	$		$ 68,398	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 68,398	25

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 W. MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ (696)	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						28,170	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						4,923	5
6	10	NURSING	Direct Allocation						16,408	6
7	11	ACTIVITIES	Direct Allocation						34	7
8	20	DUES, FEES, SUBSCRIPTIONS	Direct Allocation						41	8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation							10
11	39	ANCILLARY	Direct Allocation						18,979	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 67,860	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,497,287	32	$ 9,406	$	64,775	$ 407	1
2	05	Utilities	Patient Days	1,497,287	32	59,188		64,775	2,561	2
3	06	Maintenance	Patient Days	1,497,287	32	144,661		64,775	6,258	3
4										4
5	17	Administration	Patient Days	1,497,287	32	97,000		64,775	4,196	5
6	19	Professional Fees	Patient Days	1,497,287	32	543,148		64,775	23,497	6
7	20	Dues and Subscriptions	Patient Days	1,497,287	32	127,217		64,775	5,504	7
8	21	Office & Clerical	Patient Days	1,497,287	32	472,845		64,775	20,456	8
9	24	Travel and Seminar	Patient Days	1,497,287	32	123,511		64,775	5,343	9
10	26	Insurance	Patient Days	1,497,287	32	44,126		64,775	1,909	10
11	30	Depreciation	Patient Days	1,497,287	32	616,575		64,775	26,674	11
12	32	Interest	Patient Days	1,497,287	32	102,930		64,775	4,453	12
13	33	Real Estate Taxes	Patient Days	1,497,287	32	48,662		64,775	2,105	13
14	34	Rent - Building	Patient Days	1,497,287	32	230,488		64,775	9,971	14
15	35	Rent - Equipment & Auto	Patient Days	1,497,287	32	41,530		64,775	1,797	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,661,288	$		$ 115,131	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,497,287	32	107,276	107,276	64,775	4,641	1
2										2
3	06	Maintenance Salary	Patient Days	1,497,287	32	130,484	130,484	64,775	5,645	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,497,287	32	34,158		64,775	1,478	4
5										5
6	10a	Rehab Salary	Patient Days	1,497,287	32	14,139	14,139	64,775	612	6
7	15	Emp. Ben. - Healthcare	Patient Days	1,497,287	32	1,933		64,775	84	7
8					32					8
9	17	Administration Salary	Patient Days	1,497,287	32	783,083	783,083	64,775	33,877	9
10	21	Office Salary	Patient Days	1,497,287	32	4,281,771	4,281,771	64,775	185,236	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,497,287	32	726,674		64,775	31,437	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,079,517	$ 5,316,753		$ 263,010	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	928,452		46,000		10,409	516	1
2	02	Food	Income			160,931			2,134	2
3	06	Maintenance	Billable Income	928,452		1,614		10,409	18	3
4	17	Administration	Billable Income	928,452		11,797		10,409	132	4
5	19	Professional Fees	Billable Income	928,452		262		10,409	3	5
6	20	Dues & Subscriptions	Billable Income	928,452		342		10,409	4	6
7	21	Office & Clerical	Billable Income	928,452		27,087		10,409	304	7
8	24	Travel & Seminar	Billable Income	928,452		9,381		10,409	105	8
9	26	Insurance	Billable Income	928,452		8,379		10,409	94	9
10	30	Depreciaton	Billable Income	928,452		4,499		10,409	50	10
11	32	Interest	Billable Income	928,452		15,077		10,409	169	11
12	35	Rent - Equipment & Auto	Billable Income	928,452		843		10,409	9	12
13	39	Ancillary Enteral Supplies	Income			327,517			3,342	13
14	01	Dietary - Salary	Billable Income	928,452		160,568	160,568	10,409	1,800	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	928,452		24,382		10,409	273	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 798,679	$ 160,568		$ 8,953	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Business Partners. LLC		X	Mortgage			$	$ 10,736,282			$ 179,571	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Diawa		X	Line of Credit				4,362,587			60,940	6
7	Shareholder Loan	X		Line of Credit				585,000			4,972	7
8	See Supplemental Schedule										4,453	8
9	TOTAL Facility Related						$	$ 15,683,869			$ 249,936	9
	B. Non-Facility Related*											
10	Interest Income		X								(1,726)	10
11	Interest Income (Building Co)		X								(14,038)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (15,764)	14
15	TOTALS (line 9+line14)						$	$ 15,683,869			$ 234,172	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11	Allocation Care Centers		X								4,453	11
12												12
13												13
14	TOTAL Working Capital										4,453	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 225,556	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 221,693	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,863)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 230,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 226,637	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	241,566	8
	2001	247,849	9
	2002	250,628	10
	2003	214,787	11
	2004	219,588	12

RE Accrual - $219,588 x 1.03=$230,500

Care Center Allocation - $2,105

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-05-402-027-0000	Long Term Care Property	$ 109,779.17	$ 109,779.17
2.	14-05-402-028-0000	Long Term Care Property	$ 109,779.17	$ 109,779.17
3.	Home Office	See Attached	$ 48,662.44	$ 2,105.21
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 268,220.78	$ 221,663.55

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sheridan Shores Care & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040444

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	2201 Main LLC Allocation			$ 15,215	1
2	Facility			690,923	2
3	TOTALS			$ 706,138	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	42,874		20	2,145	2,145	26,451	9
10	Various			1994	57,552		20	2,878	2,878	33,319	10
11	Various			1995	146,433		20	7,322	7,322	78,009	11
12	Various			1996	67,704		20	3,385	3,385	32,480	12
13	Various			1997	53,902		20	2,696	2,696	23,040	13
14	Various			1998	172,679		20	8,637	8,637	65,594	14
15	Various			1999	62,682		20	3,134	3,134	20,562	15
16	Various			2000	149,525		20	7,503	7,503	41,403	16
17	Various			2001	56,462		20	2,823	2,823	13,492	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		4,446,256	115,269		115,269		115,269	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		59,713	2,448		2,448		7,375	68
69	Financial Statement Depreciation			43,932			(43,932)		69
70	TOTAL (lines 4 thru 69)		$ 5,315,782	$ 161,649		$ 158,240	$ (3,409)	$ 456,994	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,315,782	$ 161,649		$ 158,240	$ (3,409)	$ 456,994	1
2	Hot Water Heater	2002	11,675		20	1,168	1,168	4,573	2
3	Toilet R & M	2002	747		20	75	75	299	3
4	Ceiling Fans	2002	700		20	70	70	280	4
5	Doors	2002	1,199		20	60	60	240	5
6	Deposit On Don Office Remodeling	2002	1,859		20	186	186	744	6
7	Water Pump Leaking	2002	2,449		20	245	245	980	7
8	Roof Maintenance	2002	3,800		20	380	380	1,520	8
9	Electric Wiring	2002	615		20	62	62	246	9
10	New Water Pressure Valve	2002	656		20	131	131	525	10
11	Nurse Call System	2002	2,100		20	140	140	560	11
12	Tile Outlet-Tiles	2002	990		20	66	66	259	12
13	Elevator Repair	2002	1,110		20	56	56	213	13
14	Plumbing Repair	2002	565		20	57	57	217	14
15	Boiler Repair	2002	594		20	50	50	186	15
16	Cooling Tower Repair	2002	541		20	54	54	203	16
17	A/C Repair	2002	852		20	71	71	266	17
18	Power Tron Repair	2002	1,791		20	179	179	672	18
19	Countertops	2002	2,300		20	230	230	863	19
20	Plumbing Repair	2002	690		20	69	69	253	20
21	Boiler Repair	2002	1,334		20	111	111	408	21
22	Doors	2002	1,050		20	53	53	193	22
23	Sump Pump R & M	2002	2,214		20	221	221	793	23
24	Plumbing Repair	2002	824		20	82	82	295	24
25	Plumbing Repair	2002	2,940		20	294	294	1,054	25
26	Antennas	2002	1,065		20	213	213	763	26
27	Door	2002	635		20	32	32	114	27
28	Hvac Feeders	2002	5,252		20	438	438	1,568	28
29	Freezer R&M	2002	1,848		20	264	264	924	29
30	Hvac R&M	2002	599		20	60	60	210	30
31	Antennas	2002	1,065		20	213	213	746	31
32	Timeclock Installation	2002	759		20	152	152	519	32
33	Ceiling Tile	2002	758		20	38	38	126	33
34	TOTAL (lines 1 thru 33)		$ 5,371,358	$ 161,649		$ 163,760	$ 2,111	$ 477,806	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,371,358	$ 161,649		$ 163,760	$ 2,111	$ 477,806	1
2	Powertron Repair	2002	777		20	78	78	278	2
3	Booster Circuit For Water Booster	2002	516		20	52	52	194	3
4	Leasehold Improvements	2002			20				4
5	Roof	2002	1,050		20	105	105	341	5
6	Vertical Blinds	2002	2,034		20	203	203	661	6
7	Boiler	2002	1,876		20	188	188	610	7
8	Drywall	2002	850		20	85	85	276	8
9	Electric	2002	826		20	165	165	537	9
10	Bathroom Remodeling	2002	3,276		20	328	328	1,283	10
11	Water Heater	2003	2,282		20	456	456	1,369	11
12	Keypad Panel W/ Transformer	2003	1,538		20	308	308	923	12
13	Keypad Panel W/ Transformer	2003	1,070		20	214	214	642	13
14	Plumbing Repair	2003	570		20	57	57	171	14
15	Doors	2003	1,315		20	263	263	789	15
16	Elevator Repairs	2003	1,229		20	123	123	369	16
17	Ejector Pump	2003	2,741		20	548	548	1,645	17
18	Boiler Repairs	2003	1,389		20	139	139	417	18
19	Water Heater	2003	808		20	162	162	472	19
20	Roofing	2003	700		20	70	70	204	20
21	Roofing	2003	700		20	70	70	198	21
22	Roofing	2003	700		20	70	70	198	22
23	First Floor Construction	2003	9,833		20	983	983	2,786	23
24	Pipeing	2003	5,854		20	585	585	1,659	24
25	Hvac Repairs	2003	2,669		20	534	534	1,512	25
26	Plumbing Repair	2003	670		20	134	134	380	26
27	Lobby Remodeling	2003	10,500		20	1,050	1,050	2,888	27
28	Bathroom Remodeling	2003	1,850		20	185	185	509	28
29	Painting Material	2003	542		20	108	108	298	29
30	Lobby Remodeling - Addl Work	2003	2,501		20	250	250	667	30
31	Elevator Repair	2003	661		20	132	132	353	31
32	Elevator Repair	2003	823		20	165	165	439	32
33	Wall Repair	2003	774		20	77	77	206	33
34	TOTAL (lines 1 thru 33)		$ 5,434,282	$ 161,649		$ 171,647	$ 9,998	$ 501,080	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,434,282	$ 161,649		$ 171,647	$ 9,998	$ 501,080	1
2	Cooling Tower	2003	1,652		20	330	330	881	2
3	Nurses Call Repair	2003	665		20	133	133	355	3
4	First Floor Construction	2003	588		20	59	59	152	4
5	Hot Water Heater Repair	2003	857		20	171	171	443	5
6	Birch Fire Door	2003	5,574		20	1,115	1,115	2,787	6
7	Parking Garage Repairs	2003	1,925		20	193	193	481	7
8	Parking Garage Repairs	2003	2,709		20	271	271	655	8
9	2 Lavatories	2003	1,216		20	243	243	588	9
10	Parking Garage Repair	2003	4,770		20	477	477	1,113	10
11	Boiler Repair	2003	3,630		20	726	726	1,694	11
12	Parts For Door	2003	784		20	157	157	366	12
13	Detector Edge In Elevator	2003	556		20	111	111	260	13
14	Storage Tank	2003	2,323		20	465	465	1,045	14
15	Security System Key Switches	2003	885		20	177	177	398	15
16	Door Locks	2003	2,017		20	403	403	908	16
17	Parking Garage Repair	2003	3,693		20	369	369	800	17
18	Smoke Detectors Installed	2003	4,021		20	804	804	1,743	18
19	Pump W/ Motor	2003	977		20	195	195	423	19
20	Repairs And Parts For Boiler	2004	658		20	132	132	252	20
21	Repairs And Parts For Exhaust Fans	2004	1,227		20	245	245	470	21
22	Bypass Hoses & Exhaust System	2004	2,814		20	563	563	1,079	22
23	Installation Of Iron Fence	2004	3,790		20	379	379	726	23
24	New Motor	2004	926		20	185	185	340	24
25	Repair Of Air Conditioning System	2004	1,768		20	354	354	619	25
26	Elevator Repairs	2004	500		20	100	100	167	26
27	Generator Maintenance	2004	1,171		20	234	234	371	27
28	Repair On Walk-In-Freezer	2004	501		20	100	100	159	28
29	Removal Of Heavy Duty Shoring	2004	3,373		20	337	337	506	29
30	Elevator Repair	2004	604		20	60	60	91	30
31	Elevator Repair	2004	604		20	121	121	171	31
32	Fire Service Upgrade	2004	35,300		20	3,530	3,530	5,001	32
33	New Compressor	2004	1,826		20	365	365	517	33
34	TOTAL (lines 1 thru 33)		$ 5,528,186	$ 161,649		$ 184,751	$ 23,102	$ 526,641	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,528,186	$ 161,649		$ 184,751	$ 23,102	$ 526,641	1
2	Heater Repair And Parts	2004	1,480		20	148	148	210	2
3	Door Signs	2004	544		20	109	109	154	3
4	Shower & Tub Rooms	2004	560		20	56	56	75	4
5	Tower & Exhaust Repairs	2004	614		20	61	61	82	5
6	Small Passenger Elevator Repairs	2004	1,661		20	166	166	208	6
7	Large Passenger Elevator Repairs	2004	955		20	95	95	119	7
8	Small Passenger Elevator Repairs	2004	604		20	60	60	76	8
9	Large Passenger Elevator Repairs	2004	1,435		20	144	144	179	9
10	Water Pump Repairs	2004	1,173		20	117	117	147	10
11	Safety Glass	2004	560		20	56	56	70	11
12	Elevator Repair	2004	623		20	62	62	73	12
13	Small Passenger Elevator Repairs	2004	2,325		20	233	233	271	13
14	Small Passenger Elevator Repairs	2004	2,325		20	233	233	271	14
15	New Carpeting	2004	2,337		20	334	334	389	15
16	New Floor Tile	2004	1,627		20	108	108	127	16
17	Generator Maintenance	2004	791		20	79	79	92	17
18	Fire Alarm System	2004	2,100		20	210	210	228	18
19	Small Elevator Repairs	2004	5,425		20	271	271	294	19
20	Large Elevator Repairs	2004	1,214		20	61	61	66	20
21	Circulating Pump In Boiler Room	2004	3,015		20	251	251	272	21
22	Domestic Hot Water	2004	526		20	44	44	47	22
23	Door Magnets, Wiring	2004	200		20	20	20	32	23
24	Wiring	2004	295		20	30	30	47	24
25	Wiring	2004	380		20	38	38	60	25
26	Acoustical And Drywall	2004	386		20	39	39	61	26
27	Acoustical And Drywall	2004	386		20	39	39	61	27
28	Condensor Fan Motor	2004	344		20	34	34	54	28
29	Scaffolding	2004	6,614		20	661	661	1,047	29
30	Wiring	2004	625		20	63	63	99	30
31	Fire Alarm (1/05)	2005	7,870		20	787	787	787	31
32	Reface Cabinets & Counter Tops (2/05)	2005	3,600		20	660	660	660	32
33	Elevator Repair (3/05)	2005	7,918		20	660	660	660	33
34	TOTAL (lines 1 thru 33)		$ 5,588,698	$ 161,649		$ 190,680	$ 29,031	$ 533,659	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,588,698	$ 161,649		$ 190,680	$ 29,031	$ 533,659	1
2	Rebuilt Circulating Pump (3/05)	2005	2,106		20	176	176	176	2
3	Repair Air Conditioner (3/05)	2005	583		20	49	49	49	3
4	Repair Hot Water Heater (3/05)	2005	774		20	65	65	65	4
5	Repairs To Boiler & Roof Exhausts (3/05)	2005	1,273		20	106	106	106	5
6	Motor Repairs (3/05)	2005	1,035		20	86	86	86	6
7	Elevator Motor Repair (5/05)	2005	279		20	77	77	77	7
8	Hot Water System Instl (5/05)	2005	6,083		20	406	406	406	8
9	Repairs To Hot Water Booster (5/05)	2005	884		20	59	59	59	9
10	Repair Fire Sprkinler (5/05)	2005	1,195		20	80	80	80	10
11	Relocate Cooler (9/05)	2005	2,656		20	89	89	89	11
12	Leasehold Improvements (9/15)	2005	3,382		20	113	113	113	12
13	Elevator Motor Overhaul (9/05)	2005	6,495		20	217	217	217	13
14	Water Heater Repair (10/05)	2005	2,674		20	67	67	67	14
15	Pump Repair (11/05)	2005	1,859		20	15	15	15	15
16	Boiler Repair (12/05)	2005	1,874		20	8	8	8	16
17	Curtains (11/05)	2005	1,966		20	16	16	16	17
18	Parking Garage (8/05)	2005	381,112		20	28,984	28,984	28,984	18
19									19
20									20
21									21
22									22
23									23
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	1
2									2
3									3
4									4
5									5
6									6
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	1
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	1
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5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,004,929	$ 161,649		$ 221,293	$ 59,644	$ 564,272	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	188		2005	1977	$ 4,394,437	$ 112,678	39	$ 112,678	$	$ 112,678	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Site Improvement			2005	51,819	2,591	20	2,591		2,591	9
10											10
11											11
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36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
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68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,446,256	$ 115,269		$ 115,269	$	$ 115,269	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main, LLC Allocation		2002	2002	$ 20,967	$ 538		$ 538	$	$ 1,770	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main LLC Allocation			2002	17,320	866	20	866		3,031	9
10	2201 Main LLC Allocation			2003	20,412	1,021	20	1,021		2,551	10
11	2201 Main LLC Allocation			2005	1,014	23	20	23		23	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 59,713	$ 2,448		$ 2,448	$	$ 7,375	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 645,300	$ 21,664	$ 78,437	$ 56,773	10	$ 430,699	71
72	Current Year Purchases	621,454	59,152	61,649	2,497	10	61,649	72
73	Fully Depreciated Assets	65,750				10	65,750	73
74								74
75	TOTALS	$ 1,332,504	$ 80,816	$ 140,086	$ 59,270		$ 558,098	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Centers, Inc.		2005	$ 29,213	$ 2,140	$ 2,140	$	5	$ 22,122	76
77										77
78										78
79										79
80	TOTALS			$ 29,213	$ 2,140	$ 2,140	$		$ 22,122	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 8,072,784	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 244,605	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 363,519	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 118,914	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,144,492	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 885,100			3
4	Additions	Parking Lot Rental			12,000			4
5	Allocation Care Centers				9,971			5
6								6
7	TOTAL				$ 907,071 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 4,431 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 45,949	$		$ 45,949	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			48,974			48,974	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				71,555		71,555	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						48,655		48,655	13
14	TOTAL			$		$ 94,923	$ 120,210		$ 215,133	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,805	$ 135,608	1
2	Cash-Patient Deposits	80,288	80,288	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	974,747	1,205,247	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	112,330	112,330	6
7	Other Prepaid Expenses	9,886	9,886	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	448,639	448,639	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,628,695	$ 1,991,998	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		690,923	13
14	Buildings, at Historical Cost		4,394,437	14
15	Leasehold Improvements, at Historical Cost	1,384,253	1,436,072	15
16	Equipment, at Historical Cost	785,352	1,372,636	16
17	Accumulated Depreciation (book methods)	(805,126)	(979,123)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	4,596,737	4,837,155	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,961,216	$ 11,752,100	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,589,911	$ 13,744,098	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 700,391	$ 700,391	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	73,069	73,069	28
29	Short-Term Notes Payable	4,362,587	4,362,587	29
30	Accrued Salaries Payable	193,292	193,292	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,656	10,656	31
32	Accrued Real Estate Taxes(Sch.IX-B)		230,500	32
33	Accrued Interest Payable	123,254	184,003	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	4,928,862	607,091	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,392,111	$ 6,361,589	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	585,000	585,000	39
40	Mortgage Payable		10,736,282	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 585,000	$ 11,321,282	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,977,111	$ 17,682,871	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,387,200)	$ (3,938,773)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,589,911	$ 13,744,098	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,650,240)	1	
2	Restatements (describe):		2	
3	**Depreciation**	(48,018)	3	
4	**Bank Charges**	(140)	4	
5	**Equity**	(2,522,008)	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,220,406)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	833,206	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 833,206	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,387,200)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,385,351	1
2	Discounts and Allowances for all Levels	(460,168)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,925,183	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	397,794	6
7	Oxygen	17,330	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 415,124	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,432	16
17	Sale of Drugs	67,332	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	26,932	19
20	Radiology and X-Ray	1,670	20
21	Other Medical Services	22,234	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 124,600	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,726	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,726	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,190	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,190	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,479,823	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,268,597	31
32	Health Care	2,404,532	32
33	General Administration	1,205,064	33
	B. Capital Expense		
34	Ownership	1,450,361	34
	C. Ancillary Expense		
35	Special Cost Centers	215,133	35
36	Provider Participation Fee	102,930	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,646,617	40
41	**Income before Income Taxes (line 30 minus line 40)****	833,206	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 833,206	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	979	1,051	$ 30,093	$ 28.63	1
2	Assistant Director of Nursing	1,687	1,911	53,011	27.74	2
3	Registered Nurses	12,550	13,990	357,943	25.59	3
4	Licensed Practical Nurses	27,580	31,854	670,061	21.04	4
5	CNAs & Orderlies	87,327	94,202	828,660	8.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,326	5,230	60,320	11.53	8
9	Activity Director	921	1,028	11,876	11.55	9
10	Activity Assistants	8,587	9,113	68,664	7.53	10
11	Social Service Workers	15,236	16,283	220,009	13.51	11
12	Dietician					12
13	Food Service Supervisor	2,022	2,194	35,863	16.35	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,172	4,611	42,857	9.29	15
16	Dishwashers	17,189	18,813	153,408	8.15	16
17	Maintenance Workers	14,215	15,306	176,487	11.53	17
18	Housekeepers	19,184	20,430	154,660	7.57	18
19	Laundry	7,560	8,243	73,271	8.89	19
20	Administrator	2,081	2,205	66,195	30.02	20
21	Assistant Administrator	2,099	2,036	17,631	8.66	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,349	7,744	87,132	11.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,850	2,295	34,616	15.08	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	236,914	258,539	$ 3,142,757 *	$ 12.16	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,318	01-03	35
36	Medical Director	Monthly	4,100	09-03	36
37	Medical Records Consultant	Montthly	2,153	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,820	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	196	11-03	44
45	Social Service Consultant	21	4,270	12-03	45
46	Other(specify)				46
47	Psychiatrist	35	3,525	10-03	47
48					48
49	TOTAL (lines 35 - 48)	60	$ 28,382		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Corey J Nigro	Administrator	0	$ 66,195
Nathan Langsner	Assistant Administrator	0	17,631
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,826

B. Administrative - Other

Description	Amount
Nathan Langsner - Management Fees	$ 60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 60,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rolthblatt	Accounting	$ 18,953
Care Centers, Inc.	Accounting	14,047
Care Centers, Inc.	Bookkeeping	61,770
Personnel Planners	Unemployment Consult	3,439
Legat Architects, Inc.	Architect	1,319
BDO Seidman	Audit Fee	842
SMS	Medicare Consulting	5,163
Care Centers, Inc.	Computer Consulting	5,954
E-Health Data Solutions	MDS Software	1,770
Care Centers, Inc.	Payroll	4,081
ADP	Payroll	6,382
See Supplemental Schedule		8,478
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 132,199

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 86,833
Unemployment Compensation Insurance	65,542
FICA Taxes	235,850
Employee Health Insurance	87,430
Employee Meals	25,806
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	2,940
Employee Physicals	2,116
Pension Expense	23,912
Misc Employee Welfare	4,657
Holiday Expense	1,865
TOTAL (agree to Schedule V, line 22, col.8)	$ 536,952

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,821
Health Care Worker Background Check	
(Indicate # of checks performed 104)	2,153
Dues & Subscriptions	10,734
Licenses & Fees	3,411
Advertising & Promotion	12,654
Care Center Allocation	5,508
Less: Public Relations Expense	( )
Non-allowable advertising	(12,654)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,627

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,948
Education Expense	561
Allocation from Care Centers Inc.	5,343
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,852

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sheridan Shores Care & Rehab Ctr # 0040444 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC - $9,238**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,079** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **102,930**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **25,806** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.